NAMI Connecticut
National Alliance on Mental Illness

Testimony before the Joint Human Services and Public Health Committees

September 3, 2009

Subject Matter: Privatization and Relocation of Services delivered by the Departments of Mental Health and Addiction Services (DMHAS)

Good morning, chairs and distinguished members of the Human Services and Public Health Committees. My name is Alicia Woodsby, and I am the Public Policy Director for the National Alliance on Mental Illness in CT (NAMI-CT). NAMI-CT is the state's largest grassroots statewide membership organization working on behalf of people with serious mental illnesses and their family members. I also serve as co-chair of the Keep the Promise Coalition, a statewide coalition of people living with mental illnesses, family members and mental health professionals dedicated to advocacy for a community based mental health service system and housing options for adults and children in Connecticut with mental illnesses.

First and foremost, I want it to be clear that the primary concern for both NAMI-CT and the Keep the Promise Coalition is access to quality and appropriate services for people with serious mental illnesses in this state - AND NOT who provides those services. For us, the debate with regard to whether or not Cedarcrest Hospital should be closed is not about the facility or public versus private providers, but rather a larger systems issue related to system capacity and options for community based services and housing to the greatest extent possible in line with the Supreme Court Olmstead decision. The question is not simply what happens to the persons currently served at Cedarcrest Hospital, but where will other people get their services after the hospital closes.

Cedarcrest is an old facility which costs millions of dollars to maintain; dollars desperately needed for community mental health services and housing for persons now unnecessarily hospitalized or homeless. In fact, it is estimated that 30% of Cedarcrest patients do not require hospital level of care. However, the state cannot afford to close Cedarcrest if it decreases access to inpatient admissions and does not invest in a community based mental health system and housing. The loss of 60 beds from the inpatient system will exacerbate our emergency room crisis and aggravate existing gridlock.

The Administration has proposed several plans that may meet short term needs, but they do not address the ongoing demand for inpatient beds and stable housing that promotes recovery. They reflect the same approach used when the state closed two large state psychiatric facilities in the 1990's. The state failed to keep its promise to provide a comprehensive community based system. As a result, persons with psychiatric disabilities were unnecessarily institutionalized in hospitals, jails and nursing homes or living in shelters, and forced to rely on high cost emergency room care. While it generated short term savings, it served neither the persons with disabilities nor taxpayers, and we are still dealing with the consequences. Let's not repeat the same mistake.

The good news is that there is an approach that addresses these issues. The state can provide Medicaid coverage for extended intermediate care at private hospitals, which would reduce the demand for state hospitals, maintain the current inpatient capacity, and generate more Medicaid revenue. Two to three pilot inpatient programs in "high demand" urban areas such as Hartford, Bridgeport or New Haven of 4-5 beds each would admit an expected 35 patients per year, resulting in 70 to 105 patients treated in the community each year. This compares to 103 beds at Cedarcrest with admissions of about 167 per year, and combined with the 42 beds transferred to CT Valley Hospital and Bridgeport would sustain the state's current capacity. Both housing and community support services are required to allow for timely discharge and to account for those who are ready to move to the community. The state can close Cedarcrest while assuring access to intermediate care beds and funding housing rental vouchers and associated support services – for less than it costs to operate Cedarcrest Hospital.

The Governor's last proposal recommended the development of four 15-bed residential facilities at an approximate cost of $1.5 million/facility. The cost of these 15 bed facilities can be shifted to more flexible housing and support approaches with the goal of integrating people with serious mental illnesses in stable community living. Without providing for community housing with supports, the proposed 15 bed facilities are likely to become long term mini-institutions adding to even more gridlock in community hospitals. This was the case in Minnesota when they closed the state hospital beds and developed 15 bed facilities to maximize Medicaid match. Over time, they discovered these beds functioned as long term care mini-institutions, so they contracted with community hospitals for extended acute care beds.

Community support teams are necessary to work with patients and hospital staff in the intermediate care general hospital beds on discharge plans *from the point of admission* to the hospital. This will prevent gridlock in these beds, and allow turnover for other patients needing extended inpatient care. This is the same approach being used in DMHAS' approved Home and Community Based Waiver to discharge people for serious mental illnesses in nursing homes. Under the Waiver, these services are eligible for Medicaid reimbursement.[1] DMHAS and DSS could use a state plan amendment to extend Medicaid reimbursement to these inpatient services, providing a significant offset to state cost.

Housing vouchers are a critical component to ensuring that the closure does not exacerbate gridlock and transinstitutionalization trends. In order to discharge patients who are admitted to intermediate inpatient beds in a timely way, both housing and community support services are required. We propose that DMHAS receive 60 Housing rental vouchers, which they directly administer and are attached to patients who are ready for discharge from a state hospital or general hospital intermediate care bed.

The provision of community based service dollars to address the needs of individuals transitioning to the community will only serve to fill current gaps in the community system if we continue to chronically under fund mental health providers. Mental health providers cannot sustain the current and proposed cuts. They were already in a state of crisis before the Governor's recent and immediate 20% cut. This cut was a devastating blow that forces them to serve fewer individuals and cut essential programs, as well as lay off valuable staff members. In

[1] These services already have federal Medicaid approved rates and definitions.

addition to adequately funding nonprofit mental health providers, service dollars must be directly attached in a specific, dedicated line item in the plan for closure of Cedarcrest inpatient beds. The attached alternative proposal provides further details and figures related to our proposal.

Do not waste more dollars by investing in bricks and mortar through long term mini-institutions or facility renovations. We urge state policymakers to use this opportunity to improve care and reduce gridlock in both emergency rooms and inpatient settings - **and keep its promise to persons with psychiatric disabilities and their families.**

Thank you for time and attention. I am happy to answer any questions.

Cedarcrest Alternative Housing, Community Support & Intermediate Bed Proposal

Background. The Appropriations Committee is considering the Governor's proposed closure of Cedarcrest Hospital and an overall net reduction of 60 hospital beds with the proposed consolidation with CVH. Given the well documented gridlock in emergency rooms around the state, and the needs of patients that need longer, intermediate stays of 30-90 days, this proposed reduction may further aggravate an already existing problem. It is our understanding that given the staff DMHAS will likely lose to the retirement incentive program, it may be difficult for DMHAS to keep Cedarcrest open and staffed adequately. The proposal outlined below addresses the needs of people who must have intermediate inpatient care as well as require community supports and housing for stable community living. When a state hospital closes, we should use this as an opportunity to improve care and reduce gridlock in both emergency rooms and inpatient settings.

This proposal provides an alternative to the Governor's plan to close Cedarcrest (should you decide to accept the closure), and we believe a better approach over the long term. It maximizes federal funds to support the cost of care, and provides permanent support for community living. Our proposal sets aside a portion of the net savings of $12.2 million over the biennium and reallocates funds from the four proposed 15 bed institutional settings to ensure adequate access to community hospitals for intermediate care and for stable community living.

This approach is consistent with the recommendations of the Governor's Hospital System Strategic Task Force (2008), co-chaired by Secretary Genuario and Commissioner Vogel to address the gridlock problem. Their report, issued last year, confirmed the need to "reduce the inappropriate use and/or the extended lengths of stay for emergency department patients waiting to receive mental health and/or substance abuse services by increasing capacity to provide such services in the appropriate setting within identified "high demand" areas". Without addressing both the need for intermediate inpatient beds and the need to be able to discharge and help people live stable lives in the community with affordable housing, the emergency room crisis will escalate. Currently, DMHAS has estimated that 20 to 30% of patients now in Cedarcrest could be in the community if adequate housing and support services were available.

In the Governor's budget proposal from May, there is a recommendation for developing four 15-bed facilities at an approximate cost of $1.5 million/facility. Our proposal recommends shifting the cost of those 15 bed facilities to more flexible housing and support approaches with the goal of integrating people with serious mental illnesses in stable community living. Without providing for community housing with supports, the proposed 15 bed facilities are likely to become long term mini-institutions adding to even more gridlock in community hospitals.

Proposal. Establish two to three pilot programs in "high demand" urban areas such as Hartford, Bridgeport or New Haven to provide intermediate hospital care. Using data from the existing program at Natchaug Hospital, the average length of stay in such programs are 45 days. Programs similar in size to the Natchaug program (4-5 beds) would admit an expected 35 patients per year, resulting in 105 patients treated in the community each year. This compares to Cedarcrest admissions of about 167 per year. In Fiscal 2008, 150 adults were held two or more nights in the Hartford Hospital ED, most waiting for intermediate level care.

Estimated Costs. Based on the 128 referrals from Hartford Hospital Emergency Department to State-operated psychiatric beds for intermediate care during FY 2008 (Cedarcrest, Capital Regional MHC), we are projecting a similar payer mix for the intermediate care programs that would be established under this proposal.

Payer Mix & Projected Days – Per Intermediate Bed Program

Payer	%	Admissions	Days
Medicare	34%	12	540
Medicaid	37%	13	585
No Insuran	23%	8	360
SAGA	7%	2	90
		35	1,575

1. **Costs for Patients with no Insurance**. Using average Medicaid FFS per diems for Hartford Hospital and St. Vincent's acute psychiatric stays we have used an estimated rate of $1,025 per day. Total costs per program for those

without insurance would be $369,000 or **$738,000 for two pilot programs** (this is the high end estimate as it does not account for the actual reconciled rate).

2. **Increased Costs for Medicaid.** To implement this program, the Department of Social Services will need to partner with DMHAS to establish an enhanced rate for those selected providers in "high demand' areas that develop intermediate care programs, since Medicaid currently pays ***per discharge***, rather than per day for care in general hospital psychiatric units. This is a timely change since Medicare now pays ***per day*** for psychiatric care. This change will clearly also help to leverage additional federal funding to support needed intermediate care, and with the higher federal match during the next two years, will serve to reduce the net costs to Connecticut of this care if it is provided in community hospitals eligible for Medicaid reimbursement. Projected Medicaid costs for this proposed enhanced rate (over the current per discharge reimbursement) would be **$970,000 for two programs, with net cost to the state after federal Medicaid incentives of $435,000.** This may be able to be absorbed within current caseload and utilization assumptions within the DSS budget.

3. **Housing vouchers**—In order to discharge patients who are admitted to intermediate inpatient beds in a timely way, both housing and community support services are required. We are proposing that DMHAS receive 60 Housing rental vouchers, which they directly administer and are attached to patients who are ready for discharge from a state hospital or general hospital intermediate care bed. **At an estimated cost of $8,000/voucher, the cost to the state would be $480,000**

4. **Community Support Services**—Community support services targeted to the high demand areas of Hartford, Bridgeport, and/or New Haven would be provided to work with patients in the intermediate care general hospital beds and hospital staff on a discharge plan *from the point of admission* to the hospital. This will prevent gridlock in these beds, and allow turnover for other patients needing extended inpatient care. This is the same approach being used in DMHAS' approved Home and Community Based Waiver to discharge people for serious mental illnesses in nursing homes. Under the Waiver, these services are eligible for Medicaid reimbursement.[1] DMHAS and DSS could use a state plan amendment to extend Medicaid reimbursement to these services, providing a significant offset to state cost. **The cost of the teams without Medicaid reimbursement is approximately $500,000 /team.** [2] The model is based on a successful program at a DMHAS funded Local Mental Health Authority, with community support staff including psychiatrists, nurses, clinicians, case managers, and an employment specialist. Additional DMHAS service dollars must be directly attached in a specific, dedicated line item in the plan for closure of Cedarcrest inpatient beds. This is the only way the state can ensure ongoing community based mental health service dollars for people transitioning to the community, so that we are not cutting from the community system at the same time we are greatly increasing our reliance on its resources.

5. **Total Costs.** Total costs in FY 2011 are $8,708,000. After realizing Medicaid match for the intermediate beds in general hospitals, actual net costs are lower. The net costs could be further reduced should the state seek Medicaid reimbursement for the Community Support Teams. **Please note** that a significant percentage of the estimated costs below would apply to SFY 2010 depending upon the time schedule for implementation.

SFY 2011

	2 Pilots	3 Pilots
Intermediate Bed Program	$ 738,000	$ 1,107,000
Medicaid Costs (Gross)	$ 970,000	$ 1,455,000
Community Support Programs	$ 1,000,000	$ 1,500,000
Housing Vouchers	$ 480,000	$ 480,000
Dedicated Service Dollars	$ 5,520,000	$ 5,520,000
Total Gross Costs	$ 8,708,000	$ 10,062,000
Medicaid Revenues - Intermediate	$ 435,000	$ 875,000
Net Cost - After Federal Match	$ 8,273,000	$ 9,187,000
Net Cost with Service Match	**$ 7,773,000**	**$ 8,437,000**

[1] These services already have federal Medicaid approved rates and definitions.

[2] Note that if Cedarcrest is closed, there may be state staff who can provide staffing for one or more of these teams with no additional cost to the state.